

Declaration of Good Health Form

Instructions: Please complete all sections honestly. This form is required to confirm your current medical fitness to work.

Employee Name:

Employee ID (if applicable):

Department:

Position/Job Title:

Date:

Current Health Status:

- ☐ I do not have a fever, cough, or shortness of breath
- ☐ I have not experienced flu-like symptoms in the past 14 days
- ☐ I have not been in contact with anyone diagnosed with infectious diseases (e.g., COVID-19) in the past 14 days
- ☐ I am not currently under any medical treatment that prevents me from performing my work duties

If you have any health conditions, please specify:

I, the undersigned, hereby declare that the information provided above is true and correct to the best of my knowledge.

I understand that supplying false information could lead to disciplinary action.

Employee Signature:

Date:

Print Form